TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-15-2964-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted

Amount in Dispute: $247.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed for filling a prescription of a Lenzapatch to the claimant. A Lenzapatch is a compound of Lidocaine and Menthol. ODG indicates Lidocaine has an "N" status as a topical. Texas Mutual has no record preauthorization was sought or obtained nor has the requestor provided any evidence of preauthorization approval in its DWC60 packet. It appears the requestor provided the drug anyway without obtaining preauthorization as required by Rule 134.530."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2015	Lenzapatch 4%1%	$247.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.530 sets out requirements for use of the closed formulary for claims not subject to certified networks.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes;
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
    - 784 – Service exceeds recommendations of treatment guidelines (ODG).

Issues

1. What is the applicable rule?
2. Is the requestor entitled to reimbursement?

Findings

1. Review of the TX COMP claim profile at https://txcomp.tdi.state.tx. finds, no active Certified network. Therefore, the applicable rule is 28 Texas Administrative Code §134.530 which states in pertinent part, "(b) Preauthorization for claims subject to the Division's closed formulary.

   (1) Preauthorization is only required for:

   (A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

   (B) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and

   (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a)."

   Review of the submitted medical claim finds;

   a. LenzaPatch: Generic name, (lidocaine & menthol)
   b. Appendix A, ODG Workers' Compensation Drug Formulary lists – Topical analgesics - "Lidocaine" – with a status of "N"
   c. State of Pharmacy Services / DWC066 (no prior authorization present)

   Prior authorization was required for this medication but was not obtained. Requirements of Rule 134.530 were not met.

2. As no documentation was found to support prior authorization requirement met, no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 11, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.